SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Term Life	SERFF Tr Num: AEGX-126393294	State: Arkansas
TOI: L04G Group Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 44153
Sub-TOI: L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num: TL AR0053615F01	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: SPI ADMSLH	Disposition Date: 11/23/2009
	Date Submitted: 11/20/2009	Disposition Status: Approved-Closed
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: Term Life	Status of Filing in Domicile:
Project Number: TL AR0053615F01	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Association
Filing Status Changed: 11/23/2009	Explanation for Other Group Market Type:
	State Status Changed: 11/23/2009
Deemer Date:	Created By: SPI ADMSLH
Submitted By: SPI ADMSLH	Corresponding Filing Tracking Number:

Filing Description:

RE: Group Life Insurance Applications GUL033(05)AR, GUL034(05)AR, GUL060(05)AR, GUL061(05)AR, and GUL062(05)AR

The five referenced applications for group life insurance are submitted for your review and approval. Each application replaces an existing application that was previously approved by your Department. The referenced applications contain the life insurance replacement question that is required per Rule 97 to be on life insurance applications used with direct response marketed group life policies. The applications will be used on and after January 1, 2010.

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

The applications are designed to be used in Arkansas only and, thus, are not required to be filed in the company's domicile state of Vermont.

Applications GUL033 (05)AR, GUL034(05), and GUL062(05)AR will be used when soliciting out of state group term to age 65 life insurance policy GM274. The policy is issued to various association and credit card groups that are situsted in Illinois. The policy and certificate GC274 were approved by your Department on 9/16/1999.

Applications GUL060 (05)AR and GUL061(05) will be used when soliciting out of state group term to age 65 life insurance policies GM267 and GM287. The policies are issued to various association and credit card groups that are situsted in Illinois. Policy GM267 and certificate GC267 were approved by your Department on 2/12/1998. Policy GM287 and certificate GC287 were approved by your Department on 3/3/2004.

Company and Contact

Filing Contact Information

Sam Hunt, Manager, Product Filing & Compliance	shunt@aegonusa.com	
20 Moores Road	610-648-5816 [Phone]	
Frazer, PA 19355	610-648-4703 [FAX]	

Filing Company Information

Stonebridge Life Insurance Company	CoCode: 65021	State of Domicile: Vermont
29 South Main Street	Group Code: 468	Company Type: Life and Health
Rutland, VT 05701-5014	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 03-0164230	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	$100.00	11/20/2009	32204568

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/23/2009	11/23/2009

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Disposition

Disposition Date: 11/23/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Form Schedule

Lead Form Number: GUL033(05)AR

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GUL033(05)AR	Application/ Enrollment Form	Application	Initial		47.600	GUL033(05)AR.PDF
	GUL034(05)AR	Application/ Enrollment Form	Application	Initial		47.200	GUL034(05)AR.PDF
	GUL060(05)AR	Application/ Enrollment Form	Application	Initial		44.800	GUL060(05)AR.PDF
	GUL061(05)AR	Application/ Enrollment Form	Application	Initial		47.400	GUL061(05)AR.PDF
	GUL062(05)AR	Application/ Enrollment Form	Application	Initial		47.600	GUL062(05)AR.PDF

Underwritten Term Life Insurance

Yes! Please enroll me for the Group Term Insurance Plan
Please check the rate chart for your benefit and premium based on your age, gender and tobacco usage.

Benefit Requested: $50,000.00 **Premium Amount: $11.00**

Enroll me for the Group Life Insurance Plan under the Group Policy issued to JCPenney. I also understand that in order to enroll for this coverage, I, the applicant, must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age 18 through 60, and reside in a state in which this insurance may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

John Q. Public
1000 Anywhere Street
Any Town, USA 75000

Date of Birth: 01/05/1968
Home Telephone: 972-222-2222
Tobacco user within the last 12 months? ☐ Yes ☐ No

☐ Male ☐ Female

(A) During the past five (5) years have you sought or received treatment or medical advice or been hospitalized for cancer, stroke, diabetes, blood pressure, or for a disease of the heart, liver, kidneys, intestines, respiratory system, or for nervous, neuromuscular, or connective tissue disorder?	☐ Yes ☐ No
(B) During the past five (5) years have you sought or received treatment or medical advice or been hospitalized for alcoholism, drug abuse or been arrested or cited for the use of alcohol or drugs, or has your license to drive been suspended or revoked?	☐ Yes ☐ No
(C) Have you ever received medical diagnosis or treatment by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency disorder, or tested positive on an AIDS-related test?	☐ Yes ☐ No
(D) Will this coverage replace, discontinue or change an existing policy or contract?	☐ Yes ☐ No

Beneficiary Designation: Any amount due for loss will be paid to you if living. Unless you specify below, any other benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any (including stepchildren and adopted children); otherwise equally to your then living parents or parent; otherwise to your estate.

Beneficiary: **Jane Q. Public** Relationship: **Wife**

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

X _____ _____
Insured's Signature Date

Underwritten Term Life Insurance

Yes! Please enroll me for the Group Term Insurance Plan with Accidental Death Coverage
Please check the rate chart for your benefit and premium based on your age, gender and tobacco usage.

Benefit Requested: $50,000.00 **Accidental Death: $50,000.00** **Premium Amount: $11.00**

Enroll me for the Group Life Insurance Plan under the Group Policy issued to JCPenney. I also understand that in order to enroll for this coverage, I, the applicant, must be a JCPenney Credit Cardholder or the spouse of a JCPenney Credit Cardholder, age 18 through 60, and reside in a state in which this insurance may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

John Q. Public
1000 Anywhere Street
Any Town, USA 75000

Date of Birth: 01/05/1968
Home Telephone: 972-222-2222
Tobacco user within the last 12 months? ☐ Yes ☐ No

☐ Male ☐ Female

(A) During the past five (5) years have you sought or received treatment or medical advice or been hospitalized for cancer, stroke, diabetes, blood pressure, or for a disease of the heart, liver, kidneys, intestines, respiratory system, or for nervous, neuromuscular, or connective tissue disorder?	☐ Yes ☐ No
(B) During the past five (5) years have you sought or received treatment or medical advice or been hospitalized for alcoholism, drug abuse or been arrested or cited for the use of alcohol or drugs, or has your license to drive been suspended or revoked?	☐ Yes ☐ No
(C) Have you ever received medical diagnosis or treatment by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency disorder, or tested positive on an AIDS-related test?	☐ Yes ☐ No
(D) Will this coverage replace, discontinue or change an existing policy or contract?	☐ Yes ☐ No

Beneficiary Designation: Any amount due for loss will be paid to you if living. Unless you specify below, any other benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any (including stepchildren and adopted children); otherwise equally to your then living parents or parent; otherwise to your estate.

Beneficiary: **Jane Q. Public** Relationship: **Wife**

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

X _____ _____
Insured's Signature Date

Home Office: Rutland, VT
Administrative Office:
2700 West Plano Parkway
Plano, Texas 75075-8200

Stonebridge Life Insurance Company

APPLICATION FORM

FOR GROUP TERM LIFE INSURANCE PLAN

Benefit Amount:
$
Premium Amount:
$

Applicant's Full Name _____ Date of Birth _____ (Month/Day/Year) Age _____ ☐ Male ☐ Female

Address _____ (Street No. City State Zip) Telephone _____ (Area Code - Number)

Occupation _____ Height _____ (Ft. In.) Weight _____ (Lbs.) Birth Place _____ (City State)

Beneficiary/Relationship _____ Tobacco user within the last 12 months? ☐ Yes ☐ No

Physician's Name & Address _____ (Street No. City State Zip)

Please Check Benefit Amount Desired:

	Monthly Premium			
	Male		Female	
	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User
☐ $10,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $30,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $50,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $70,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $100,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX

Please choose from the following Rider options:

☐ $5,000 Child Rider for each child ☐ $15,000 Accidental Death Benefit Rider

Child's Full Name (only if child coverage is selected) List youngest child first	Gender	Date of Birth
	☐ M ☐ F	/ /
	☐ M ☐ F	/ /

Attach a separate page for additional children.

To the best of your knowledge and belief, have you:

A. sought or received treatment or medical advice or been hospitalized for cancer, stroke, diabetes, blood pressure, or for any disease of the heart, blood, liver, kidneys, digestive or respiratory system, or for any nervous, mental, neuromuscular, or connective tissue disorder during the past five (5) years? Yes ☐ No ☐

B. sought or received treatment or medical advice or been hospitalized for alcoholism, drug abuse or been arrested or cited for the use of alcohol or drugs, or has your license to drive been suspended or revoked during the past five (5) years? Yes ☐ No ☐

C. ever been treated or diagnosed by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency disorder or tested positive on an AIDS-related blood test? Yes ☐ No ☐

If answer is "yes" to any of the above questions, please supply complete details. Include diagnosis and name, address, and date for any doctors consulted. Attach a separate sheet of paper and check this box. ☐

I understand that in order to apply for this coverage, I must be a JCPenney credit cardholder or the spouse of a JCPenney credit cardholder, age XX-XX, and reside in a state in which this insurance coverage may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

Will this coverage replace, discontinue or change an existing policy or contract? ☐ Yes ☐ No

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application form. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application form.

Applicant's Signature X _____ Date X _____

GUL060(05)AR

Home Office: Rutland, VT
Administrative Office:
2700 West Plano Parkway
Plano, Texas 75075-8200

Stonebridge Life Insurance Company

APPLICATION FORM

FOR GROUP TERM LIFE INSURANCE PLAN

Benefit Amount:
$
Premium Amount:
$

Applicant's Name (First – Middle – Last)				Spouse's Name (First – Middle – Last) (if applying for coverage)			
Address		☐ Male ☐ Female		Address		☐ Male ☐ Female	
City	State		Zip	City	State		Zip
Birthdate / /	Age	Birthplace (City/State)	Telephone ( )	Birthdate / /	Age	Birthplace (City/State)	Telephone ( )
Height (Ft. In.)	Weight (Lbs.)	Occupation		Height (Ft. In.)	Weight (Lbs.)	Occupation	
Beneficiary (First – Middle – Last)		Relationship		Beneficiary (First – Middle – Last)		Relationship	
Physician's Name & Address				Physician's Name & Address			
Tobacco user within the last 12 months? ☐ Yes ☐ No				Tobacco user within the last 12 months? ☐ Yes ☐ No			
Please Check Benefit Amount Desired: ☐ $10,000 of coverage ☐ $70,000 ☐ $30,000 of coverage ☐ $100,000 ☐ $50,000 of coverage				Please Check Benefit Amount Desired: ☐ $10,000 of coverage ☐ $70,000 ☐ $30,000 of coverage ☐ $100,000 ☐ $50,000 of coverage			
Please choose from the following Rider options: ☐ $15,000 Accidental Death Benefit Rider ☐ $5,000 Child Rider for each child				Please choose from the following Rider options: ☐ $15,000 Accidental Death Benefit Rider ☐ $5,000 Child Rider for each child			
Child's Full Name (only if child coverage is selected.) List youngest child first.		Gender	Date of Birth	Child's Full Name (only if child coverage is selected.) List youngest child first.		Gender	Date of Birth
		☐ M ☐ F	/ /			☐ M ☐ F	/ /
Attach a separate page for additional children.				Attach a separate page for additional children.			

To the best of your knowledge and belief, have you:

	Applicant	Spouse
A. sought or received treatment or medical advice or been hospitalized for cancer, stroke, diabetes, blood pressure, or for any disease of the heart, blood, liver, kidneys, digestive or respiratory system, or for any nervous, mental, neuromuscular, or connective tissue disorder during the past five (5) years?	☐ YES ☐ NO	☐ YES ☐ NO
B. sought or received treatment or medical advice or been hospitalized for alcoholism, drug abuse or been arrested or cited for the use of alcohol or drugs, or has your license to drive been suspended or revoked during the past five (5) years?	☐ YES ☐ NO	☐ YES ☐ NO
C. ever been treated or diagnosed by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency disorder or tested positive on an AIDS-related blood test?	☐ YES ☐ NO	☐ YES ☐ NO

If answer is "yes" to any of the above questions, please supply complete details. Include diagnosis and name, address, and date for any doctors consulted. Attach a separate sheet of paper and check this box. ☐

I understand that in order to apply for this coverage, I must be a JCPenney credit cardholder or the spouse of a JCPenney credit cardholder, age XX-XX, and reside in a state in which this insurance coverage may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

Will this coverage replace, discontinue or change an existing policy or contract? You: ☐ Yes ☐ No Your Spouse: ☐ Yes ☐ No

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application form. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application form.

Applicant's Signature	Date	Spouse's Signature	Date

Home Office: Rutland, VT
Administrative Office:
2700 West Plano Parkway
Plano, Texas 75075-8200

Stonebridge Life Insurance Company

APPLICATION FORM

FOR GROUP TERM LIFE INSURANCE PLAN

Benefit Amount:
$
Premium Amount:
$

Applicant's Full Name _____ Date of Birth _____ (Month/Day/Year) Age _____ ☐ Male ☐ Female

Address _____ (Street No. City State Zip) Telephone _____ (Area Code - Number)

Occupation _____ Height _____ (Ft. In.) Weight _____ (Lbs.) Birth Place _____ (City State)

Beneficiary/Relationship _____ Tobacco user within the last 12 months? ☐ Yes ☐ No

Physician's Name & Address _____ (Street No. City State Zip)

Please Check Benefit Amount Desired:

	Monthly Premium			
	Male		Female	
	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User
☐ $10,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $30,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $50,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $70,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX
☐ $100,000 of coverage at your current age of XX costs	$XX.XX	$XX.XX	$XX.XX	$XX.XX

Please choose from the following Rider options:

☐ $5,000 Child Rider for each child ☐ $15,000 Accidental Death Benefit Rider

Child's Full Name (only if child coverage is selected) List youngest child first	Gender	Date of Birth
	☐ M ☐ F	/ /
	☐ M ☐ F	/ /

Attach a separate page for additional children.

To the best of your knowledge and belief, have you:

A. sought or received treatment or medical advice or been hospitalized for cancer, stroke, diabetes, blood pressure, or for any disease of the heart, blood, liver, kidneys, digestive or respiratory system, or for any nervous, mental, neuromuscular, or connective tissue disorder during the past five (5) years? Yes ☐ No ☐

B. sought or received treatment or medical advice or been hospitalized for alcoholism, drug abuse or been arrested or cited for the use of alcohol or drugs, or has your license to drive been suspended or revoked during the past five (5) years? Yes ☐ No ☐

C. ever been treated or diagnosed by a licensed physician for AIDS, HIV, AIDS Related Complex (ARC), immunodeficiency disorder or tested positive on an AIDS-related blood test? Yes ☐ No ☐

If answer is "yes" to any of the above questions, please supply complete details. Include diagnosis and name, address, and date for any doctors consulted. Attach a separate sheet of paper and check this box. ☐

I understand that in order to apply for this coverage, I must be a JCPenney credit cardholder or the spouse of a JCPenney credit cardholder, age XX-XX, and reside in a state in which this insurance coverage may legally be offered. If accepted, and premiums are paid, I understand the Certificate is not effective until the effective date specified on my Certificate Schedule Page.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, consumer reporting agency (CRA), insurance support organization (ISO), or the Medical Information Bureau (MIB) to give Stonebridge Life Insurance Company (company) or its reinsurers any information it has in its records on me or any member of my family to use for underwriting insurance. The company may disclose information to MIB and, except for information received from MIB, to any CRA, ISO, or to any life insurance company to whom I apply for insurance or request benefits. This authorization shall be valid for two years from the date of this application form. A photocopy of this authorization shall be as valid as the original, and a copy is available to the applicant on request. I have received and read the Medical Information Bureau Notice accompanying this application form.

Will this coverage replace, discontinue or change an existing policy or contract? ☐ Yes ☐ No

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Applicant's Signature X _____ Date X _____

GUL062(05)AR

SERFF Tracking Number:	*AEGX-126393294*	*State:*	*Arkansas*
Filing Company:	*Stonebridge Life Insurance Company*	*State Tracking Number:*	*44153*
Company Tracking Number:	*TL AR0053615F01*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Term Life*		
Project Name/Number:	*Term Life/TL AR0053615F01*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
AR - READABILITY CERTIFICATION.PDF

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: n/a
Comments:

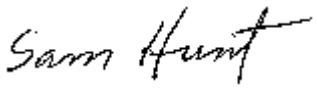
STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **Stonebridge Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GUL033(05)AR	47.6
GUL034(05)AR	47.2
GUL060(05)AR	44.8
GUL061(05)AR	47.4
GUL062(05)AR	47.6

Signed: 

Name: Sam Hunt

Title: Manager, Product Filing & Compliance

Date: 11/20/2009